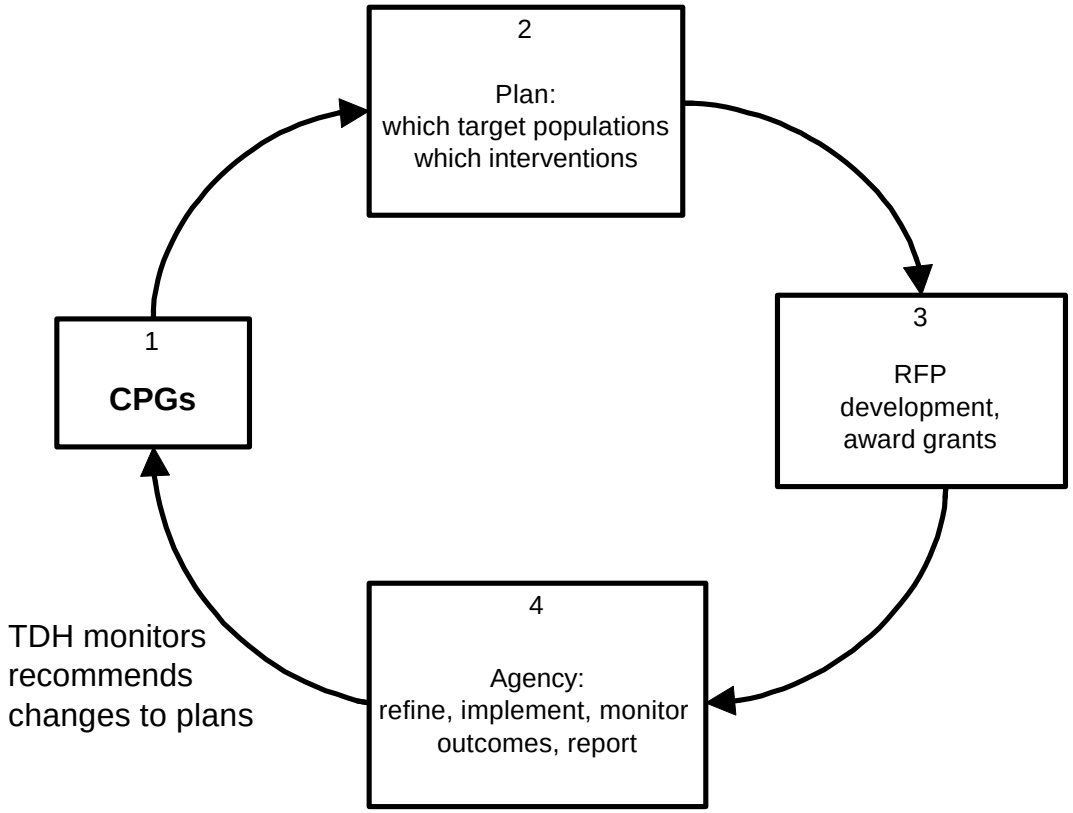
How does Community Planning for HIV/STD Prevention Work in Texas?

Generally, we can think of HIV prevention planning in Texas as a wheel, with four major points on interest along the rim (see Figure 1).

Figure 1. Community Planning Wheel.



First, Community Planning Groups (CPGs) familiarize themselves with the HIV Epidemic profile http://www.tdh.state.tx.us/hivstd/profiles/2000/default.htm , which contains morbidity information on AIDS and HIV cases and three major STDs :primary & secondary syphilis, gonorrhea and chlamydia cases. The Epidemic Profile also contains risk profiles based on information provided by clients during HIV prevention counseling sessions. The CPGs reviewed this information, and developed needs assessments and resource inventories to determine needs and additional risk information about at-risk populations for the plan development.

The CPGs then take this information, and develop a plan (2), which describes specific target populations, through risk behavior, sex, race, ethnic group, and age group. For each target population, the CPG will also identify risk behaviors and factors which influence those behaviors, and identify interventions that will

address those risk behaviors. This plan, or Area Action Plan (AAP) is developed independently for each of the six CPGs in Texas.

Third, TDH takes the AAP and develops a Request for Proposal (RFP), reviews the proposals, identifies organizations with capacity to perform the work proposed, negotiates and awards contracts for specific prevention activities in specific target populations.

The contracted agency then carries out the interventions (4), monitors implementation, immediate outcomes for their interventions, refines methods for implementation as needed based on outcome and implementation monitoring. These refinements will be brought to the attention of regional coordinators, field operations consultants and consultants from the Research & Program Evaluation branch for their review of sound documentation and final approval for operational changes.

Based on outcome monitoring, and implementation issues, TDH may recommend to CPGs that additional interventions be offered or they may identify or remove additional target populations from the current plan. This then goes to the CPG for discussion and refinement of the community plan (1). CPGs can also determine if new interventions and target populations are appropriate to be included in plans in future years based on continued needs assessment and resource inventory results.

Then the wheel of HIV prevention planning continues to roll.

Community Planning Groups – what do they do? [link cpgfq1]

What qualifies CPGs to do this work? [link cpgfq2]

What do CPGs use to be able to identify effective interventions? [link cpgfq3]

What does intent to deliver the specific intervention to a specific target audience mean?

It means, quite literally, that when a staff member leaves their office to provide a specific intervention, that they know exactly what target population they are **intending** to provide the intervention for, and have clearly defined objectives for this intervention in this specific target population. If a staff member leaves their office without a specific-predefined intervention to provide or a specific target population to reach, the CDC and TDH will consider this “outreach”.

Are there interventions that the CDC considers effective?

Yes. The Compendium of Effective Interventions (ftp://ftp.cdcnpin.org/Reports/HIVcompendium.pdf) is a listing of interventions that meet CDC's strict criteria for effectiveness (hereafter referred to as the compendium). You will notice that most of the interventions in this document have structured curriculum and tend to be multisession in nature. Since interventions specified in community plans will primarily come from the Compendium, we need to rethink how current prevention activities will occur under the new plan.

What Factors Influence Behavior (FIBs)?

The needs assessment and risk profile information will help identify risky behaviors in a specific sub-population and factors that influence these risky behaviors (FIBs). The following table lists some FIBs used in Texas with their definitions, and examples of each factor. The full table of FIBs used in community planning are here [link cpgfq4]

Table 2. Factors which influence behavior.

Factors which Influence Behavior (FIB)	Description of FIB	Example of FIB
Stereotypical beliefs about who's at risk and misconceptions about how HIV/STDs and HCV are spread	A person may believe that he is not at risk because he doesn't have sex with gay men, even though he engages in risky behaviors with multiple female partners. There may be false assumptions about the "type" of person who gets HIV/STD/HCV, or a person may hold false beliefs about how HIV/STDs/HCV is transmitted.	"basically, only IV drug users and gay men are really at risk" "I would never eat there, I've heard all the waiters are gay"
The illusion of invulnerability	A personal belief that one is immune to risk, and that it's OK to engage in high-risk behaviors. A related notion is "optimistic bias". People generally tend to underestimate their personal risk in comparison to the risk faced by others who are engaging in the same behaviors as they are.	"Yeah, I know what they say about the odds, but I just don't think it will happen to me"
Fatalism	A belief that circumstances are beyond one's control. Nothing a person does will change what is going to happen anyway. The degree of fatalism a person adopts may be affected by the options he believes are available to him – fewer options can lead to a greater sense of fatalism.	"I'm young and gay, so AIDS is going to get me eventually. I might as well enjoy myself while I'm here"

(version as of 7/19/01)

These FIBs are all based on theories of behavior change and are covered in detail in a class developed through funding by the CDC and offered by the

Prevention Training Center II in Dallas (Bridging Theory and Practice: Applying Behavioral Theory to STD/HIV Prevention). For planning purposes, you do not need to know the details of the behavior theories that each FIB belongs to, but just that these factors which influence risky behaviors may need to be addressed by interventions directed toward your target populations.

Each FIB is a piece of an individual's behavior, or a rationale for continuing risky or unhealthy behaviors. An intervention can address one or many FIBs and many interventions may address the same FIBs in your target population. This is where the CPGs expertise and knowledge of the community come into play, they will rank or identify the most important factors in each target population that need to be addressed, based on their review of morbidity and risk factors in your community.

From these high priority FIBs, CPGs will then identify specific interventions which have been effective at addressing these FIBs. CPGs may find that a specific sub-population does not have a specific intervention addressing a set of particular FIBs. Here they might need to be less specific about the interventions that we should provide, or they may wish to modify an intervention developed for another population which addresses those FIBs, or they may request documentation of effectiveness an intervention that is currently in place in their community as an action item for TDH to review and discuss.

Once CPGs have identified the interventions appropriate for these target populations, field operations and RPE staff will examine these interventions for:

- Effectiveness
- The basic requirements of the agency to implement the program and maintain its quality
- Develop appropriate outcome monitoring guidelines and monitoring issues
- Discuss technical assistance needs for implementation

What do CPGs need to know to be able to identify effective interventions?

- Who is affected (target population defined by HIV Epidemic Profile and needs assessments)
- Why are they at-risk (FIBs from risk profile and needs assessments)
- How to best reduce risk in the target population (needs assessments, resource inventory, list of effective interventions)
- Where should interventions be performed (needs assessments, resource inventory, list of effective interventions)

Where do the CPGs get their interventions?

CPGs will draw interventions primarily from:
the CDC's Compendium of Effective Interventions (ftp://ftp.cdcnpin.org/Reports/HIVcompendium.pdf) We suggest that all field

operations staff become familiar with that document and the interventions outlined within.

but CPGs may use other sources such as:

- SAMHSA – effective drug prevention interventions. (http://www.samhsa.gov/csap/modelprograms/default.htm).
- UCSF – Center for AIDS Prevention Studies (CAPS) (http://www.caps.ucsf.edu/capsweb/projectindex.html).
- SF Community plan – various interventions determined by the San Francisco planning group to be effective and satisfactory for use in San Francisco (http://www.dph.sf.ca.us/HIVPrevPlan/page2.html) - see chapter 4 for summary of programs and bibliography.
- HRSA – (http://hab.hrsa.gov/evaluation.html).

Remember that CPGs can suggest any intervention in the AAP that has been shown to be effective.

What is the end-product of the CPG process, the Area Action Plan (AAP)? [link cpgfq5]

Using the information from the AAP, the provider will examine the plan, and determine what parts of the plan they can carry out, and what kinds of interactions with other agencies they need to be able to provide comprehensive coverage for the target population.

Why do the AAPs need to be so specific?

- The needs assessment process provides very specific information on the risk behaviors and FIBs that need to be addressed in that community and that need to be known to specify interventions for that population. To specifically respond to the needs of the population, CPGs need to provide specific details on how that population needs to be reached and with what tools.
- By being specific in the AAP, the task for the CBO during the RFP response is made easier since the intervention, target population and immediate outcomes are defined in the plan. This allows the CBO more time to concentrate on carrying out and monitoring immediate outcomes of the intervention and time to take an overall look at the needs of the target population in that community and to address how they are meeting all needs of the target population.
- Need to address contract monitoring needs, both CBO to TDH and internally at TDH through TDH regulations.
- Specific reporting requirements by the CDC outlined in the evaluation guidance.